

Frequently Asked Questions: Preventive Medicine

Review Committee for Preventive Medicine

ACGME

Institutions

If the sponsoring institution is expected to provide funds for residents to attend a national professional meeting, is the sponsor expected to cover the full cost including travel, and is there a limit to how much the sponsor is expected to cover?

[Program Requirement I.A.1.]

The sponsoring institution must ensure that every resident is afforded the opportunity to attend a national meeting. The sponsor is expected to provide funds to cover the usual costs of attending a national meeting, including registration fees, travel, lodging, and meals. There is no specific upper limit to what this would require of the institution.

Program Personnel and Resources

What specialty qualifications are acceptable to the Review Committee if the program director does not have current certification in preventive medicine by the American Board of Preventive Medicine (ABPM)? *[Program Requirement II.A.3.b]*

In rare and unusual circumstances, the Review Committee will consider an exception to the requirement for ABPM certification for the program director. Exceptions are made on a case-by-case basis. In these cases the Committee considers physicians with certification in a specialty recognized by the American Board of Medical Specialties who have demonstrated experience in the field of preventive medicine through:

- at least five years' administrative experience;
- significant peer-reviewed publications; or,
- acknowledged work in the field.

If a program has a concentration in aerospace medicine, must its sponsor also sponsor the required flight training program? *[Program Requirement II.D.1]*

No; it is not necessary that both programs have the same sponsor. However, both programs must be geographically proximate to each other so that residents can conveniently use the flight training site. The distance between the two locations must not interfere with the residents' other program responsibilities.

Resident Appointments

What education qualifies a resident for acceptance into a preventive medicine program?

[Program Requirement III.A.1.]

The resident must have successfully completed at least 12 months of clinical education in an a residency program accredited by the ACGME, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada that provides 11 months of direct patient care in both inpatient and outpatient settings.

Is spending a month reading x-rays in a radiology rotation without physically interacting with a patient considered clinical experience? [Program Requirement III.A.1.a)]

If the experience is part of an ACGME-accredited program of which the primary focus is direct patient care (e.g., internal medicine), then reading x-rays during a radiology rotation would be considered acceptable. Such experiences during pathology or radiology residencies, for example, during the PG-1 year would not be acceptable, as the primary focus of those specialties is not direct patient care.

Is “direct patient care” only one-on-one examination and treatment of individual patients? [Program Requirement III.A.1.a)]

Direct patient care includes assessment, screening, diagnosis, and treatment of patients. The educational experiences can occur in a range of adequately supervised patient-focused clinical settings, including a tuberculosis clinic, a private practitioner’s office, a sexually transmitted disease (STD) clinic, a rural health clinic, a migrant worker clinic, or a travel medicine clinic.

Educational Program

If a resident enters the program having previously obtained a Master of Public Health (MPH) degree, is the curriculum for that resident still expected to be 24 months in length? [Program Requirements Int.C and IV.A.3.a)]

Yes; the standard length of the educational program as established by the Review Committee is 24 months, regardless of whether a resident enters with an MPH or equivalent degree.

How will the Review Committee assess compliance with the requirement that residents must complete the specified graduate-level courses? Can the required material be covered in a class not specifically named among the listed required courses, and can the material be covered in practicum experiences, such as in research analysis?

[Program Requirement IV.A.3.a)]

The program must document that each resident participated in graduate course work in the required areas, and that the resident attained sufficient competencies in those areas. This requirement can be met by combining a degree program with other didactic experience, such as a lecture series that covers topics with the same breadth, depth, and scope as a graduate-level course, and that includes evaluation methods, and that is taught by appropriately-credentialed faculty members.

For courses taken at an academic institution, documentation requirements would include a transcript and a course syllabus. For courses taught during didactic sessions, documentation requirements would include a rotation description (educational goals and objectives) and a notation of satisfactory course completion in the individual resident’s educational plan and portfolio.

Assessment of achieving competencies must be addressed (e.g., graded examination). The program must be able to document that the sum total of the didactic sessions

offered would be equivalent to a course offered in a graduate school that is sufficient to achieve the competencies in that area.

Does a course such as “Intermediate Biostatistics” qualify as an “advanced” course?
[Program Requirement IV.A.3.a)]

A course that is beyond the introductory graduate level is considered advanced. The syllabus will support the scope, breadth, and depth of a course if it is not evident in the course title. The program director must assess the appropriateness of the course.

Must the required graduate-level courses in the areas of epidemiology, biostatistics, health services management and administration, environmental health, and the behavioral aspects of health be taught as free-standing courses?
[Program Requirement IV.A.3.a)]

No. The course material may be covered in multiple courses or in one large, mega-course that includes multiple subjects.

What specific topics should be covered in each of the required course areas listed?
[Program Requirement IV.A.3.a)]

The Review Committee is planning to develop more instructive information regarding its expectations. Subcommittees will be assigned to identify the specific topics that should be included for each required course area, and their recommendations will be added to this document at a later date. In the meantime, the ABPM's *Study Guide* and the U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services* are good resources for course content.

Is there a minimum number of credits for the graduate courses required by the Committee? [Program Requirements IV.A.3.b)-IV.A.3.b).(3)]

No. There is no specific credit hour requirement, but the program director must document in each individual resident's educational plan that the specific competencies covered by the course were achieved.

What other equivalent degrees are acceptable in lieu of an MPH?
[Program Requirements Int.C and IV.A.3.a)]

Equivalent degrees may include a Master of Science in epidemiology, Master of Science in preventive medicine, Master of Science in community health, Master of Tropical Medicine and Hygiene, Master of Occupational Health, Master of Science in occupational health, Master of Science in environmental science, Master of Science in environmental toxicology, a Master of Health Sciences, a Master of Health Administration, and a Master of Business Administration. Acceptance of the exact type and name of a degree is at the program's discretion.

How must didactic conferences be structured? [Program Requirement IV.A.3.b)]

Didactic conferences (to include journal club, grand rounds, and multispecialty conferences) must facilitate faculty member and resident interaction and focus on the required competencies and learning objectives of the program.

How will the Review Committee evaluate progressive responsibility for direct patient care? [Program Requirement IV.A.4.]

Residents must continually take more responsibility for the services they deliver to their defined patients. For example, a resident must demonstrate the ability to develop progressively more complex patient care plans over time. Progressive population-based care may be demonstrated by initially developing rudimentary plans to address a problem and, later in the program, demonstrating the ability to develop complex solutions. A resident must also develop progressive teaching responsibilities related to direct patient care, which can be done by teaching more junior preventive medicine residents and other learners, as appropriate, in how to manage clinical patients and in population-based problem solving. One way the Committee will evaluate progressive responsibility is through review of the schedule; PM-2 rotation descriptions and goals/objectives must be different from those of the PM-1.

Curriculum Organization and Resident Experiences

Is there flexibility in how much direct patient care must be accomplished during each year of the program? [Program Requirements IV.A.6.b).(2), IV.A.6.c).(2), and IV.A.6.d).(2)]

No; direct patient care must be completed as outlined in the requirements for each year of the program, as reiterated here:

- **Aerospace Medicine:** Residents must have a minimum of four months of direct patient care experience during each year of the program.
- **Occupational Medicine:** Residents must have a minimum of four months of direct patient care experience in an occupational setting during each year of the program.
- **Public Health and General Preventive Medicine:** Residents must have a minimum of two months of direct patient care experience during each year of the program.

Can the required minimum duration of direct patient care experiences be distributed across the academic year, or must it be completed in a solid block?

[Program Requirements IV.A.6.b).(2)]

The experience can be divided. The minimum shift is a half-day, and 20 days equals one month. An experience obtained during 40 half-days in a clinic that provides direct patient care is equivalent to one month of direct patient care.

During the required direct patient care experience, can a resident participate in activities such as Objective Structured Clinical Examination (OSCE) and other simulated patient encounters, clinical rounds involving patients, and laboratory patient care activities (e.g., reading malaria and parasitology slides, reading x-rays of TB patients)?

[Program Requirements IV.A.6.b).(2), IV.A.6.c).(2), and IV.A.6.d).(2)]

OSCEs and other simulation tools are high-quality evaluation tools and can supplement, but not replace, experience with direct patient care.

Does prior clinical education fulfill the requirement for direct patient care?

[Program Requirements IV.A.6.b).(2), IV.A.6.c).(2), and IV.A.6.d).(2)]

No; clinical education and experience prior to commencement of the preventive medicine program would not be counted toward fulfillment of the requirement for the minimum number of months of direct patient care. Direct patient care experience during the program should focus on preventive medicine competencies.

Does a rotation at a facility of the Department of Veteran Affairs (VA) count as experience at a governmental public health agency? *[Program Requirement IV.A.6.d).(4)]*

No; a VA facility is not a governmental public health agency. The agency must provide public health oversight of a population, as defined by regulatory and legal authority. A rotation at a VA could fulfill clinical requirements or other preventive medicine requirements, but does not count towards the required two months of experience at a governmental public health agency. If a program wants the Review Committee to consider a specific rotation, it should submit that rotation description (including the goals and objectives) to Review Committee staff at the ACGME offices.

What must be included in settings that would be acceptable locations for programs with a concentration in aerospace medicine? *[Program Requirement IV.A.6.b)]*

Programs with a concentration in aerospace medicine must include access to actual or analogs (research or training) of extreme environments such as altitude chambers, bed rest facilities, (spaceflight analog) centrifuges, hyperbaric chambers, and in-flight training (real exposures and association with direct crew contact). Other acceptable settings where operational aeromedical problems are routinely encountered include flight medicine clinics, medical certification referral centers, and flight control centers (such as NASA), where residents will learn about medical flight rules, life support systems, medical care systems, and how to provide medical care through telemedicine.

What would satisfy the direct patient care experience requirements for an occupational medicine setting? *[Program Requirement IV.A.6.c).(2)]*

In addition to the traditional and customary inpatient and outpatient clinical settings for occupational medicine residents (i.e., occupational medical inpatient consultation services, industrial clinics, etc.), residents may work in inpatient and outpatient preventive medicine services where they evaluate, develop treatment plans, treat, and counsel for the prevention component of diseases that result in hospital admissions. In outpatient clinics, residents may screen, treat, and counsel for the prevention component of diseases that result in outpatient visits. In comprehensive outpatient public health clinics, residents can engage with patients who were screened and treated for occupational-related illnesses and injuries, or can screen, treat, and counsel patients with tuberculosis or STDs. The clinical setting could also include engaging with patients regarding family planning and well-child care. (See *“Examples of Preventive Medicine Training Opportunities”* from the Graduate Medical Education Committee of the American College of Preventive Medicine for additional examples.)

Must the Resident Learning Portfolio exist in electronic format?

[Program Requirement IV.A.6.e)]

No; the Review Committee does not require that the Learning Portfolio be developed in an electronic format.

Evaluation

What is an acceptable size for the Residency Advisory Committee (RAC)?

[Program Requirement V.C.3.]

The Review Committee does not provide a specific formula for representation on the RAC since every program context is different. The number of RAC members will vary according to the size of the program. It must include the specific representation and fulfill its responsibilities in accordance with Program Requirements V.C.3.b)-V.C.3.b).(7). Noncompliance in a number of areas will necessitate review of the RAC's effectiveness. If a RAC appears not to be effective in fulfilling its responsibilities, the Review Committee may cite problems related to its leadership, the committee's structure, attendance at committee meetings, or the size of or membership on the committee.

Duty Hours

Can PM-1 and PM-2 residents be supervised by any licensed allied health professionals?

[Program Requirement VI.D.1.]

PM-1 and PM-2 residents may be supervised by licensed allied health professionals who are identified as faculty members, provided that:

- the clinical care is within their scope of practice expertise;
- the level of clinical care is low risk;
- physician faculty members are available by telephone; and,
- the program director has approved the supervision with respect to the educational experience.

Allied health professionals cannot substitute for physician faculty members to meet the 24-hour requirement for on-site supervision of resident care.

What are some examples of indirect supervision? *[Program Requirement VI.D.5.a).(1)]*

Indirect Supervision with direct supervision immediately available:

The resident is seeing patients in a clinic and the supervising physician faculty member in the precepting room is immediately available to see the patient together with the resident as needed. The faculty member is in another area of the hospital, but is immediately available to see the patient together with the resident in the clinic as needed.

Indirect Supervision with direct supervision available:

A resident is on-call for the clinic service and needs advice from the physician faculty member in order to manage a patient's care. This can be done either by telephone or electronically. After communication with the resident, if the attending determines additional assistance is needed, the attending physician is available and able to go to

the clinic to see the patient together with the resident.

Indirect Supervision oversight:

A resident is seeing a patient in either the nursing home or at home, and the supervising faculty member can then review the patient chart, discuss the case and any required follow-up with the resident, and evaluate the resident.

Must every interprofessional team include representation from every profession?

[Program Requirement VI.F.]

No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee's intent is to ensure that the program has access to professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case.

Other

Do the revised requirements apply to residents already participating in the program, or do they only apply to those residents who matriculate on or after the July 2011 effective date?

The new requirements apply only to residents entering the accredited program for the 2011-2012 academic year and beyond.

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